FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031740

Facility Name: MAR KA NURSINNG HOME

Address: 201 SOUTH 10TH STREET (Number) MASCOUTAH (City) 62258 (Zip Code)

County: ST CLAIR

Telephone Number: 618-566-8000 **Fax #** ( )

IDPA ID Number: 0031740

Date of Initial License for Current Owners: 12/23/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNA CHUA **Telephone Number:** 636-394-3000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/01 to 9/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JAMES J GIARDINA
(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) DARRYL E BUEKER, CPA
(Firm Name & Address) BKD, LLP
(Telephone) 417-865-8701 Fax # 417-865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	23	Skilled (SNF)	23	8,395	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	392	863	1,545	2,800	8
9	SNF/PED					9
10	ICF	9,867	5,407	356	15,630	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,259	6,270	1,901	18,430	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.44%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/23/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/23/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,545

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/02 Fiscal Year: 9/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	121,436	8,340	4,038	133,814		133,814		133,814			1
2	Food Purchase		66,632		66,632		66,632	(412)	66,220			2
3	Housekeeping	83,268	8,522		91,790		91,790	139	91,929			3
4	Laundry	24,968	13,244		38,212		38,212		38,212			4
5	Heat and Other Utilities			56,779	56,779		56,779		56,779			5
6	Maintenance	27,334	10,882	16,903	55,119		55,119	184	55,303			6
7	Other (specify):*											7
8	**TOTAL General Services**	257,006	107,620	77,720	442,346		442,346	(89)	442,257			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	735,451	92,099	183,745	1,011,295	(50,092)	961,203		961,203			10
10a	Therapy	11,442	561	233,217	245,220		245,220		245,220			10a
11	Activities	22,356	3,295	4,159	29,810		29,810		29,810			11
12	Social Services	17,094	109	878	18,081		18,081		18,081			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* AMBULANCE			92	92		92		92			15
16	**TOTAL Health Care and Programs**	786,343	96,064	428,091	1,310,498	(50,092)	1,260,406		1,260,406			16
	C. General Administration											
17	Administrative	20,197			20,197		20,197	33,749	53,946			17
18	Directors Fees											18
19	Professional Services			97,185	97,185		97,185	(82,402)	14,783			19
20	Dues, Fees, Subscriptions & Promotions			26,752	26,752		26,752	(7,401)	19,351			20
21	Clerical & General Office Expenses	24,112	6,237	19,276	49,625		49,625	45,702	95,327			21
22	Employee Benefits & Payroll Taxes			153,617	153,617		153,617	10,282	163,899			22
23	Inservice Training & Education			4,093	4,093		4,093		4,093			23
24	Travel and Seminar			651	651		651	3,232	3,883			24
25	Other Admin. Staff Transportation							187	187			25
26	Insurance-Prop.Liab.Malpractice			44,023	44,023		44,023	52	44,075			26
27	Other (specify):* INC TAX PROV			(55,549)	(55,549)		(55,549)	55,549				27
28	**TOTAL General Administration**	44,309	6,237	290,048	340,594		340,594	58,950	399,544			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,087,658	209,921	795,859	2,093,438	(50,092)	2,043,346	58,861	2,102,207			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAR KA NURSINNG HOME #0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			27,212	27,212		27,212	42,222	69,434			30
31	Amortization of Pre-Op. & Org.							181	181			31
32	Interest			815	815		815	57,499	58,314			32
33	Real Estate Taxes			28,534	28,534		28,534		28,534			33
34	Rent-Facility & Grounds			114,000	114,000		114,000	(105,381)	8,619			34
35	Rent-Equipment & Vehicles			1,770	1,770		1,770	2,796	4,566			35
36	Other (specify):*											36
37	**TOTAL Ownership**			172,331	172,331		172,331	(2,683)	169,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		63		63		63		63			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):* LAB 2,344; RX 47,748					50,092	50,092		50,092			43
44	**TOTAL Special Cost Centers**		63	41,610	41,673	50,092	91,765		91,765			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,087,658	209,984	1,009,800	2,307,442		2,307,442	56,178	2,363,620			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(412)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,013)	21		18
19	Entertainment	(29)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,621)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	55,549	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,918)	20		28
29	Other-Attach Schedule MISC INCOME	(4,317)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 38,228		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	17,950	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,950		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 56,178		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		(2,344)	10.2	42
43	Prescription Drugs	X		(47,748)	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ (50,092)		47

STATE OF ILLINOIS

MAR KA NURSINNG HOME

ID# 0031740

Report Period Beginning: 10/1/01

Ending: 9/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (4,317)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,317)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 **Report Period Beginning:** 10/1/01 **Ending:** 9/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(412)	0	0	0	0	0	0	0	0	0	0	(412)	2
3	Housekeeping	0	0	139	0	0	0	0	0	0	0	0	139	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	184	0	0	0	0	0	0	0	0	184	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(412)	0	323	0	0	0	0	0	0	0	0	(89)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	33,749	0	0	0	0	0	0	0	0	33,749	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	32,037	1,838	(116,277)	0	0	0	0	0	0	0	(82,402)	19
20	Fees, Subscriptions & Promotions	(7,539)	0	138	0	0	0	0	0	0	0	0	(7,401)	20
21	Clerical & General Office Expenses	(9,330)	0	55,032	0	0	0	0	0	0	0	0	45,702	21
22	Employee Benefits & Payroll Taxes	0	0	10,282	0	0	0	0	0	0	0	0	10,282	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(29)	0	3,261	0	0	0	0	0	0	0	0	3,232	24
25	Other Admin. Staff Transportation	0	0	187	0	0	0	0	0	0	0	0	187	25
26	Insurance-Prop.Liab.Malpractice	0	0	52	0	0	0	0	0	0	0	0	52	26
27	Other (specify):*	55,549	0	0	0	0	0	0	0	0	0	0	55,549	27
28	**TOTAL General Administration**	38,651	32,037	104,539	(116,277)	0	0	0	0	0	0	0	58,950	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	38,239	32,037	104,862	(116,277)	0	0	0	0	0	0	0	58,861	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 **Report Period Beginning:** 10/1/01 **Ending:** 9/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	42,222	0	0	0	0	0	0	0	0	0	42,222	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(11)	57,510	0	0	0	0	0	0	0	0	0	57,499	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(114,000)	8,619	0	0	0	0	0	0	0	0	(105,381)	34
35	Rent-Equipment & Vehicles	0	0	2,796	0	0	0	0	0	0	0	0	2,796	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(11)	(14,087)	11,415	0	0	0	0	0	0	0	0	(2,683)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	38,228	17,950	116,277	(116,277)	0	0	0	0	0	0	0	56,178	45

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100%	WEST MAIN NURSING HOME	MASOUTAH	COMMUNITY CARE	BALLWIN, MO	HOME OFFICE
JAMES J GIARDINA	100%	MONMOUTH NURSING HOME	MONMOUTH	CENTERS, INC	BALLWIN, MO	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	BUILDINNG RENT	$ 114,000	JAMES J GIARDINA	100.00%	$	$ (114,000)	1
2	V	30	DEPRECIATION		JAMES J GIARDINA	100.00%	42,222	42,222	2
3	V	32	INTEREST EXPENSE		JAMES J GIARDINA	100.00%	57,510	57,510	3
4	V	31	AMORTIZATION		JAMES J GIARDINA	100.00%	181	181	4
5	V	19	HOME OFFICE	84,240	COMMUNITY CARE CENTERS, INC	COMMON	116,277	32,037	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 198,240			$ 216,190	$ * 17,950	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J GIARDINA	PRESIDENT	GENERAL DIR.	100.00	NONE	3	6.00	SALARY	$ 27,290	17.7	1
2	DOROTHY GIARDINA	VICE PRES		0.00	NONE	3	6.00	SALARY	3,723	17.7	2
3	BETTY HUGHES	SECRETARY		0.00	NONE	3	6.52	SALARY	2,735	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,748		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: COMMUNITY CARE CENTERS, INC
Street Address: 312 SOLLEY DRIVE - REAR
City / State / Zip Code: BALLWIN, MO 63021
Phone Number: (636-394-3000
Fax Number: (636-394-7713

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE	DIRECT COST			$	$		$	1
2		WEST COUNTY CARE CTR						4,666,103	238,090	2
3		ST GENEVIEVE CARE CTR						2,146,567	109,532	3
4		CCC OF LEMAY						2,045,571	104,378	4
5		SALEM CARE CTR						1,655,241	84,461	5
6		MONMOUTH NH						1,455,479	74,269	6
7		MAR-KA NH						2,278,751	116,277	7
8		WEST MAIN NH						1,005,118	51,287	8
9		CCC OF SENECA						2,501,431	127,639	9
10		MT VERNON PLACE						2,418,329	123,398	10
11		COUNTRY VIEW NH						2,037,595	103,972	11
12		MERAMEC NH						1,257,168	64,149	12
13		SEVILLE CARE CTR						2,254,668	115,050	13
14		SALEM RES CARE						448,556	22,887	14
15		BOSS RES CARE						130,198	6,644	15
16		CARL JUNCTION RES CARE						534,134	27,255	16
17		MT VERNON RES CARE						284,412	14,513	17
18		SENECA HOME PLACE						389,735	19,886	18
19		HUDSON HOUSE						407,567	20,798	19
20		MAPLE GROVE LODGE						2,182,418	111,362	20
21		SMITH BARR MANOR						739,700	37,745	21
22		CCC OF AURORA						3,702,560	188,929	22
23		BARRY COMMUNITY CARE						1,911,594	97,542	23
24		COMMUNITY IN HOME						270,328	13,793	24
25	TOTALS					$	$		$ 1,873,856	25

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST INS FUNDING CORP		X	INSURANCE FINANCING	$5,095.00	3/1/02	60,567	10,191	12/1/02	5.0000	815	6
7												7
8												8
9	TOTAL Facility Related				$5,095.00		$ 60,567	$ 10,191			$ 815	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 60,567	$ 10,191			$ 815	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$ 20,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 28,534	2
3. Under or (over) accrual (line 2 minus line 1).	$ 7,834	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 20,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 28,534	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	26,895	8
1998	27,455	9
1999	27,162	10
2000	27,565	11
2001	28,534	12

ACCRUAL - $28,534 x 9/12 = $21,400 - MISC DIFF $700 = $20,700

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAR KA NURSINNG HOME COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0031740

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31.0-114-007	LOT/SEC-31-SUBL/TWP-1N-	$ 28,270.00	$ 28,270.00
2.		BLK/RG-6W PT LOT 12C	$	$
3.		AS IN BK 2659-1974	$	$
4.	10-31.0-113-009	LOT/SEC-18 BK 2659-1974	$ 148.00	$ 148.00
5.	10-31.0-114-009	LOT/SEC-31-SUBL/TWP-1N-	$ 116.00	$ 116.00
6.		BLK/RG-6W BK 2659-1974	$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,534.00	$ 28,534.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,425 B. General Construction Type: Exterior BRICK Frame STEEL REINFORCE Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	48,000	Dec-86	$ 75,000	1
2					2
3	TOTALS	48,000		$ 75,000	3

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1986	1970	$ 950,000	$	22.5	$ 42,222	$ 42,222	$ 636,686	4
5			1986		14,621		10			14,621	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF REPAIR			1989	4,686		10			4,686	9
10	PATIO AND RAMP			1991	3,252	271	12	271		3,252	10
11	PATIO ROOF			1991	2,890		10			2,890	11
12	FLAT ROOF			1991	14,000		10			14,000	12
13	ROOF (NORTH WING)			1992	10,000	417	10	417		10,000	13
14	ROOF REPAIR			1990	7,055		10			7,055	14
15	SIDING REPAIR			1990	4,276		10			4,276	15
16	CARPET			1993	1,303		5			1,303	16
17	SPRINKLER SYSTEM			1993	2,168	87	25	87		788	17
18	BULLOCK GARAGES			1993	7,176	478	15	478		4,226	18
19	5 TON REFRIGERATION UNIT			1995	3,814	381	10	381		3,112	19
20	ROOF REPAIR			1995	18,785	1,879	10	1,879		13,847	20
21	LANDSCAPING - PATIO			1995	3,342	334	10	334		2,310	21
22	ROOFING REPAIR			1997	12,732	1,273	10	1,273		7,001	22
23	AIR CONDITIONING			1997	3,760	376	10	376		1,876	23
24	PHONE SYSTEM			1998	3,780	378	10	378		1,733	24
25	ELECTRICAL WORK			1999	3,613	181	20	181		678	25
26	COUNTERTOPS			1999	2,127	106	20	106		381	26
27	LENNOX 7.5 ROOFTOP UNIT			2000	5,733	573	10	573		1,719	27
28	ROOF ON EAST ASH WING			2000	6,400	640	10	640		1,547	28
29	MECHANICAL ROOM IMPR			2001	23,797	1,586	15	1,586		2,505	29
30	FIRE DAMPERS IN DUCT WORK			2001	1,900	116	15	116		116	30
31	FIRE DAMPERS IN DUCT WORK			2001	3,059	170	15	170		170	31
32	EXTERIOR KITCHEN DOORS			2002	1,567	59	20	59		59	32
33	RE-PLATE DOORS			2002	9,398	470	10	470		470	33
34	GAS WATER HEATER			2002	6,235	260	10	260		260	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,131,469	$ 10,035		$ 52,257	$ 42,222	$ 741,567	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 127,833	$ 13,109	$ 13,109	$	VARIOUS	$ 67,111	71
72	Current Year Purchases	25,703	1,996	1,996		VARIOUS	1,996	72
73	Fully Depreciated Assets							73
74	DISPOSALS - SCRAPPED	(11,708)	2,072	2,072		VARIOUS	(11,708)	74
75	TOTALS	$ 141,828	$ 17,177	$ 17,177	$		$ 57,399	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		95 FORD WINDSTAR VAN	FY 95	$ 17,260	$	$	$	4	$ 17,260	76
77										77
78										78
79										79
80	TOTALS			$ 17,260	$	$	$		$ 17,260	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,365,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,212	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,434	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 42,222	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 816,226	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	RETAINER FEE	$ 5,000	92
93			93
94			94
95		$ 5,000	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RELATED PARTY COSTS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,770 Description: PAGERS
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	1,367	$	92,758	$ 441	1,367	$ 93,199	1
2	Licensed Speech and Language Development Therapist		hrs		103		8,306		103	8,306	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		2,021		132,153	120	2,021	132,273	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	3,491	$	233,217	$ 561	3,491	$ 233,778	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAR KA NURSINNG HOME **#** 0031740 **Report Period Beginning:** 10/1/01 **Ending:** 9/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 67,425	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	523,115		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,824		5
6	Prepaid Insurance	27,939		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE TO/FROM REL PARTIES	(237,787)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 382,516	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	155,519		15
16	Equipment, at Historical Cost	159,578		16
17	Accumulated Depreciation (book methods)	(153,588)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP & DEPOSITS	5,119		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 166,628	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 549,144	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,283	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	391		28
29	Short-Term Notes Payable	10,191		29
30	Accrued Salaries Payable	73,966		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,752		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,700		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTY	25,247		36
37	DUE TO MEDICAID	33,481		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 298,011	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 298,011	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 251,133	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 549,144	$	48

***(See instructions.)**

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 469,074	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 469,074	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(217,941)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (217,941)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 251,133	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,327,963	1
2	Discounts and Allowances for all Levels	(869,553)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,458,410	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	507,581	6
7	Oxygen	118,027	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 625,608	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,155	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,155	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		4,317	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,317	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,089,501	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	442,346	31
32	Health Care	1,310,498	32
33	General Administration	340,594	33
	B. Capital Expense		
34	Ownership	172,331	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	41,673	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,307,442	40
41	**Income before Income Taxes (line 30 minus line 40)****	(217,941)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (217,941)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **TAX RETURN PREPARED ON CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,797	1,956	$ 39,903	$ 20.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,490	5,978	100,730	16.85	3
4	Licensed Practical Nurses	17,641	20,876	296,986	14.23	4
5	Nurse Aides & Orderlies	30,698	31,612	286,656	9.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,138	1,258	11,442	9.10	8
9	Activity Director	1,735	1,791	17,257	9.64	9
10	Activity Assistants	763	775	5,099	6.58	10
11	Social Service Workers	1,928	2,096	17,094	8.16	11
12	Dietician					12
13	Food Service Supervisor	2,015	2,151	24,810	11.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,199	6,808	52,010	7.64	15
16	Dishwashers	7,507	7,723	44,616	5.78	16
17	Maintenance Workers	2,086	2,230	27,334	12.26	17
18	Housekeepers	10,605	11,265	83,268	7.39	18
19	Laundry	3,811	4,150	24,968	6.02	19
20	Administrator	740	884	20,197	22.85	20
21	Assistant Administrator					21
22	Other Administrative	2,119	2,391	24,112	10.08	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,247	1,295	11,176	8.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,519	105,239	$ 1,087,658 *	$ 10.34	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 4,038	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	32	1,130	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	900	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	878	11.3	44
45	Social Service Consultant	16	878	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	277	$ 13,824		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	10,514	181,715	10.3	52
53	TOTAL (lines 50 - 52)	10,514	$ 181,715		53

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE LILLARD	ADMINISTRATOR	0	$ 20,197
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 20,197

B. Administrative - Other

Description	Amount
	$
NONE	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE		$
CENTERS, INC	MGMT FEES	84,240
BKD, LLP	ACCOUNTING	2,545
VAN OSTRAND & ELVIDGE	LEGAL	9,138
ROSENBLUM, GOLDENHER	LEGAL	77
HARTER & LAWSON	LEGAL	245
HUSCH & EPPENBERGER	LEGAL	33
CT CORPORATION SYSTEM	LEGAL	907
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 97,185

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,620
Unemployment Compensation Insurance	
FICA Taxes	95,379
Employee Health Insurance	24,638
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	5,687
401K CONTRIBUTIONS	2,293
HOME OFFICE ALLOCATION	10,282
TOTAL (agree to Schedule V, line 22, col.8)	$ 163,899

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,522
Health Care Worker Background Check	
(Indicate # of checks performed 50)	600
DUES & SUBSCRIPTIONS	9,417
TAXES & LICENSES	2,673
ADVERTISING OTHER	7,540
HOME OFFICE ALLOCATION	138
Less: Public Relations Expense	( )
Non-allowable advertising	(4,621)
Yellow page advertising	(2,918)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,351

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	622
MEALS	29
Seminar Expense	
HOME OFFICE ALLOCATION	3,261
Entertainment Expense	(29)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,883

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2	NONE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MAR KA NURSINNG HOME # 0031740 Report Period Beginning: 10/1/01 Ending: 9/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HCA 3,248; STL LTC ALLIANCE 6,000**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **3-15 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,610**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation. $24 for maint travel - Home Office to Mar-ka
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **TO BE SENT WHEN COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.